Illinois Department of Public Aid

POWER OF ATTORNEY

I, _____, do hereby make and appoint
(Practitioner's Name)

_____ as my true and lawful attorney
(Name of Agency)

in fact solely for the purpose of affixing my name to the DPA 1443, Provider Invoice, or DPA 2360, Health Insurance Claim Form, as appropriate. I understand and acknowledge that the person appointed must be a trusted employee over whom I have direct supervision on a daily basis or the person is employed by the hospital and must sign my name to the DPA 1443 or DPA 2360 along with his/her initials. I understand and acknowledge that said person will be acting on my behalf, and that I will be bound by the certification statement on each DPA 1443 or DPA 2360. I understand and acknowledge that this Power of Attorney in no way limits my rights, liabilities or duties relating to the provision of services under the Illinois Department of Public Aid's Medical Assistance Program. I understand and acknowledge that I retain full responsibility for all claims submitted to the Department of Public Aid under my name.

_____ Signature _____
Practitioner Name
(Printed) Date: _____

_____
Address

_____

_____

_____ Signature _____
Agent Name
(Printed) Date: _____

Completion of this form or compliance with instructions is voluntary; however, failure to do so may affect this Department's action. Form approved by the Forms Management Center.

DPA 2306 (R-8-94) IL478-1124